Volume Two/Number Two/February 1960

Call for Papers

ASHA

Journal of the American Speech and Hearing Association

ZENITH

MAKES ITS GREATEST CONTRIBUTION YET TO ALL WHO SUFFER A HEARING LOSS

The World's First HIGH FIDELITY HEARING AID

★ **Hear sounds never heard before with a hearing aid!**

★ **Virtually eliminates annoying background noise and distortion!**

To the medical profession—to all who strive for the rehabilitation of hearing loss sufferers—Zenith is proud to announce a major breakthrough in scientific progress. A new, greatly advanced hearing aid so much more beneficial to the hard of hearing that it defies comparison.

By actual test among people who wear hearing aids, this marvelous achievement has demonstrated its ability to vastly improve the hearing of 9 out of 10 wearers tested.

A brief 30 seconds is all that is required to convince almost anyone with a hearing loss that here, at last, is the closest thing to normal hearing—next to normal hearing itself.

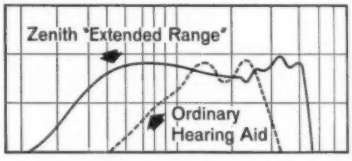
The Brand New ZENITH "Extended Range" High Fidelity Hearing Aid Excels In All These Major Advantages

BROAD RESPONSE RANGE (What it means to you)—98% greater range of sounds reproduced and amplified brings in sounds never before experienced through present conventional transistor hearing aids.

	Range of Cycles
Moderate Gain Hearing Aid	2200 cps
Previous High Gain	2800 cps
New Zenith "Extended Range"	4370 cps

Hear More Sounds—Distinguish Sound Better—You hear more sounds—and you hear them more accurately. Zenith's new "Extended Range" faithfully amplifies "unvoiced consonants" such as th, f, sh, h, most important for understanding speech. These are the whispered sounds you miss with many hearing aids. It also reproduces the "overtones or harmonics" which enable you to better distinguish between different voices and sounds.

FLAT RESPONSE—NO "PEAKS" (What it means to you)—Sounds reproduced in "peaks" are amplified more than other sounds coming to you, causing distortion in what you hear. Annoying clothing noise and restaurant clatter within these "peaks" are then over-amplified causing hearing discomfort and lack of clarity.



Far Less Distortion and Background Noise. The Zenith "Extended Range" virtually eliminates these noisy sound "peaks." Puts background sounds in proper balance with the sounds you want to hear.

Answers "Recruitment Problem". If "recruitment" (the inability to stand loud noises) bothers you, then the "Extended Range" can be your answer. All sounds are far more normal, more perfectly balanced. Nearest approach to normal hearing yet achieved.

Ideal for Telephone Conversation. Zenith's built-in Telemike feature permits "focusing" on telephone conversations by eliminating annoying room sounds. The telephone voice comes through with unbelievable clarity.

Adjustable Tonal Quality. Simple flip of a switch adjusts tone response, to emphasize high tones or low tones. Once the tone is set—it can be forgotten.

ZENITH "LIVING SOUND" HEARING AIDS

WRITE FOR THE COMPLETE STORY TODAY!

Get the latest facts on hearing aid progress! For complete information about the new Zenith "Extended Range" Hearing Aid write:

Hearing Aid Division, Zenith Radio Corporation, Dept. 550, 6501 W. Grand Avenue, Chicago 35, Illinois.

Asha

A Journal of The American Speech and Hearing Association

Volume 2 | February, 1960 | Number 2

CONTENTS

ASHA is published monthly at the Interstate Printers and Publishers, Inc., Danville, Illinois, by the American Speech and Hearing Association. Subscription: $7.00, single copy $.75. Communications on editorial, business or advertising should be addressed to the Editor, *Asha*, The American Speech and Hearing Association, 1001 Connecticut Ave., N.W., Washington 6, D. C. Address changes should reach the subscription office of The American Speech and Hearing Association by the 1st of the month preceding a change. Subscribers must notify the Post Office they will guarantee forwarding postage for undelivered copies. Other claims for undelivered copies must be made within four months of publication. Second-class postage paid at Danville, Illinois. Printed by The Interstate Printers and Publishers, Inc., 19-27 North Jackson Street, Danville, Illinois. Office of Publication, Jackson at Van Buren, Danville, Illinois.

Asha

APPLICATIONS FOR MEMBERSHIP SHOULD BE ADDRESSED TO THE EXECUTIVE SECRETARY

FORMAL CALL FOR PAPERS

Thirty-Sixth Annual Convention of the AMERICAN SPEECH AND HEARING ASSOCIATION

November 1-2-3-4-5, Statler-Hilton Hotel

Los Angeles, California

IMPORTANT NOTICE

November 1, the First day of the Convention, will be devoted exclusively to a Conference on the National Study on Public School Speech and Hearing Services.

ALL MEMBERS of the Association wishing to present papers on the program of the National Convention in 1960 are invited to submit abstracts. Consideration will also be given to abstracts from nonmembers.

The deadline for submission of abstracts is April 15; however, speakers are urged to present their abstracts early. This is particularly pertinent in view of the fact that all sections will be limited to a maximum of four speakers.

The program committee would also welcome suggestions of a general nature in regard to the program.

All communications including abstracts should be sent to:

Jack L. Bangs, Chairman
Program Committee
Houston Speech and Hearing Center
Texas Medical Center
Houston, Texas

All abstracts must include (1) the title of the paper, (2) last name, initials and advanced degree of all authors with the name of the author actually reporting the paper given first, and (3) the name of the institution or laboratory at which the research was done or with which the author is affiliated, (4) if the work was done under direction as a student, a statement to that effect, (5) a concise summary of the contents including information concerning both problem statement and findings or opinions, and (6) the time required for presentation.

In general abstracts should not exceed 300 words in length and should not be so brief that they do not do justice to the contributor. It is hoped that the program and abstracts will be published together so it is particularly pertinent that abstracts be complete and in early. All abstracts of accepted papers will be reviewed by a committee and returned for additions or corrections if found inadequate.

Submission of an abstract implies that a contributor accepts the following responsibilities: (1) He must be present in person at the scheduled time. If unforeseen circumstances prevent his appearance, he must make suitable arrangements with his chairman as far in advance as possible. (2) He must keep strictly within the time limits assigned to him by his chairman.

The Executive Council has ruled that each individual be limited to two appearances on the program to insure a wider participation of the membership. This ruling includes the presentation, or co-authoring of a paper, participating on a panel, and the like. It does not, however, limit an individual from serving as a chairman for a particular session.

It is urged that participation not be confined to experimental studies. Theoretical and practical discussion of any phase of the communicative process is welcomed. It is hoped that a large number of abstracts and program ideas will be submitted; careful consideration will be given all of them.

Individuals responsible for such functions as receptions, alumni luncheons, open houses, etc., are invited to submit the essential information to the Program Chairman for inclusion in the Convention Program.

The program Committee:

Victor Garwood	John Palmer
Joseph G. Sheehan	Howard House
Fredric L. Darley	Aram Glorig
John W. Black	Charlotte Wells
Dorothy Huntington	Dale Bingham
Henry E. Spuehler	Paul D. Knight
Newman Guttman	Freeman McConnell
Arthur S. House	Mack D. Steer
Leo Doerfler	Genevieve Arnold
Lennart L. Kopra	Janet Jeffers
Alice H. Streng	Wm. H. Perkins
James L. Shapley	Wm. Tiffany
Robert Bilger	Charles D. Parker

Stanley Ainsworth, *President*

The American Speech and Hearing Association

STANLEY AINSWORTH is Professor of Speech Correction and Chairman of the Program for Exceptional Children at the University of Georgia, where he has been on the faculty since 1953. He is also Chairman of the Speech Correction Area and a member of the University of Georgia Graduate Faculty. He serves as a member of the Advisory Panel on Speech and Hearing of the Office of Vocational Rehabilitation, Department of Health, Education and Welfare, in Washington, D.C. He is presently a Consultant to the United States Office of Education, the Georgia Department of Public Health and the Departments of Education and Divisions of Vocational Rehabilitation in Florida, Georgia, South Carolina and Alabama. As a visiting lecturer at several universities, he is noted for his keen understanding of the needs of the fields of speech and hearing and his ability to communicate these needs to students, other professional personnel and to the general public.

Dr. Ainsworth received the bachelor's degree from Michigan State Normal College in 1933 and the master's degree from the State University of Iowa in 1937. He attended Northwestern University where he obtained the Ph.D. degree in 1949. Dr. Ainsworth was the Chairman of the Speech Correction and Audiology Area, Department of Speech, at Florida State University where he taught and directed research at the graduate level.

Dr. Ainsworth's important contributions to research in the fields of speech and hearing have been published in the *Journal of Speech and Hearing Disorders*, the *Quarterly Journal of Speech* and in the *Journal of Exceptional Children*. He is the author of "Speech Correction Methods" and "Galloping Sounds." He has contributed chapters in "Speech Problems of Children, Handbook of Speech Pathology" and in "Education of Exceptional Children and Youth." He served as Associate Editor of the *Journal of Speech and Hearing Disorders* from 1948 to 1954. He has served the American Speech and Hearing Association since 1952 as a Councillor, Vice-President and Executive Vice-President. His name appears in "Who's Who in the South and Southwest" and in "Who's Who in America."

PROSPECTUS OF PROFESSIONAL STATURE: SERVICE

MARGARET HALL POWERS*
Chicago, Illinois

I HAVE been given the task this afternoon of discussing the *service* aspect of our profession's future. In thinking about what I would say I found it impossible to separate strictly a consideration of service from a consideration of training and of research, the aspects which my colleagues on this panel are to discuss. Training, service and research are closely interwoven and cannot be thought of entirely in isolation from each other. This is as it should be. So, although I will try to concentrate mainly on the service phase of our total activity, mention of research and training will creep in. My colleagues, I feel sure, will also find a complete separation of our topics impossible. What they say will have references to and implications for service as well.

Seldom in history has a profession grown as rapidly as ours. Seldom has a profession shown a greater future potential than ours. Seldom, therefore, has there been a greater need than we face today for clear thinking and wise planning for our future as a profession. Short though our history has been it has already seen a vast shift of emphasis from predominantly *research* to predominantly *service* activity. In our early years–not so very long ago–scientific curiosity and the desire to uncover facts about speech and hearing disorders were the primary motivation of workers in our field. Practical service to people with problems was an incidental by-product–fine and worthwhile but not usually the principal objective. The emphasis was on *finding out* about rather than on doing something *practical* about these disorders.

Within the space of the last fifteen or twenty years–while scientific research in speech and hearing has grown rapidly–clinical services have grown even more rapidly. Today the great majority of workers in speech and hearing, in whatever kind of setting they work, are concerned primarily with practical clinical services. Service has become an end in itself, not an incidental outcome of other professional activity. I am not commenting on the desirability of this change but only on the fact that a change has taken place. This great shift in the *proportion* of our field's total activity devoted to service is probably the most important single fact in our professional history. This fact has great implications to be faced.

Professional services in speech and hearing are evolving rapidly. What pattern are they following? How much can we as an organized profession control the pattern ourselves? Some of the social and economic forces shaping us are already well advanced and perhaps beyond our control. Other forces may still be within our control. We can be very sure that 10 or 20 years from now there will be much less that we can do than now to control our own course. Now is the time to take hold and steer, to stop drifting without aim or to leave the steering to others.

The time is already late. More consciously and systematically than ever before we must examine our professional responsibilities and plan for meeting them. We must become more concerned with how we appear to the public we serve and to other professions with whom we relate. What is the public image of our profession? What do we want the public image to be in the future? What can we do to insure that the future public image of the speech and hearing specialist will be what we want and believe to be good?

I would like now to raise some questions and problems, as I see them, which are important for us to think about and plan about for the future development of our professional services. We have taken some enormously important steps lately–the national office, an executive secretary, the development of certification standards and others. This is a good start, but *all of us* must be more and more involved than we have been in studying and planning about professional issues.

Let us first consider the meaning of professional responsibility. As any profession–including ours–begins to assume increasing *service* functions it must also assume new responsibilities and obligations. It must develop self-discipline. These needs are particularly urgent for professions which presume to deal with human disorders in a therapeutic capacity. Our profession must continue and even intensify its efforts to clarify the following aspects of its responsibility. I have identified four.

First, the profession must insure the *technical competence* of individuals who practice the profession. We have begun to do this through our certification

---

MARGARET HALL POWERS, Ph.D., is Director of the Bureau of Physically Handicapped Children and Division of Speech Correction, Chicago Board of Education, Chicago, Illinois.

*Presented at a general meeting on "What is our Association?" at the 1959 Convention of the American Speech and Hearing Association.

program. We must continue our efforts to modify and improve standards of training, to improve intra-professional certification, to secure eventually state registration for appropriate personnel and possibly even state licensure. Implicit in the term "competence" should be the issues of both content and level of training. We will have to formulate clearly an official policy regarding the contents and levels considered necessary for performing each kind of service function. The implication of this is that we must reach immediate agreement within ASHA itself on desirable standards. Internal unity of necessity will have to precede the taking of a strong public position.

Second, the profession must insure not only the technical competence but also the *ethical attitudes and practices* of its individual members. We should move away from the largely negative approach to ethics we have used up to now and should develop a more *positive, educational* approach. There are various ways to do this. One of them would be the development of a detailed ASHA statement or manual covering all matters pertaining to professional conduct and relationships. This assumes that most people would rather behave ethically than unethically if they know how. It also assumes that knowledge of what constitutes good professional behavior needs to be, can be, and has to be learned.

Third, the profession must insure the *competence of organized speech and hearing services,* whether these are clinics, school programs or agency services. We should proceed with the much-discussed and now about-to-be-implemented idea of providing a system of approval and registration of services, as well as of individuals.

The fourth aspect of our responsibility concerns our relationships with the public and with other professions. We must provide them with a *clear means of identifying* competent speech and hearing specialists. As our Executive Secretary has just said, we must take active steps to establish official, consistent terminology for what we are and what we do. We must then do all that we can individually and collectively to secure the understanding and use of this terminology and of the people and the services to which the terminology refers.

Let us consider next the issue of where professional responsibility lies. If the standards and actions just discussed are truly responsibilities of our profession, where does the initiative rest for implementing them? This is an important issue in the growth of a profession. It is easy to say "Let the ASHA office do something about this or that problem." It is easy to assume that the Committee on Clinical Standards in Speech or some other committee will think, plan and take action for us. If we are to became a true profession this cannot be the case. Let us analyze this issue of where and with whom professional responsibility rests.

First, the *training institutions* surely have some share in the public responsibility of the profession. They have an obligation to screen out those candidates for future service careers in speech and hearing who show little intellectual, personality or character potential for rendering responsible service. They should retain in clinical training programs only those who show reasonable promise of future competence and mature, ethical, professional behavior, those ingredients of clinical success which will mean benefit or harm to human beings in trouble.

We all accept the obligation of training centers to provide course offerings of sufficient depth and variety to enable the capable student to develop the knowledge and skills he will need in a service career. We less often stress the further obligation of the training center to give its clinical students systematic training in principles of *professional conduct and ethics.* The training center has the still further obligation of orienting its graduates as to the kinds of service functions they may properly undertake at the level of training they have attained. I venture to suggest that these obligations are not often met at the present time by our training centers.

A second place where professional responsibility rests is with the employer–either an individual or an organization. The responsible employer takes the trouble to inform himself about the standards of the speech and hearing profession before employing a specialist in that field. He also tries to learn something about acceptable policies and practices in this field so that he can feel certain that the speech or hearing specialist is in truth contributing to the welfare of those he serves.

Third, the state and local organizations in speech and hearing are in a particularly responsible position for carrying forward a campaign for good professional standards and for carrying on public education about the services performed by speech and hearing specialists. States are the only governmental units able to certify or license. Therefore, state organizations are in the best position of any professional agency to take action to secure a legal basis for standards and, with this basis, the elimination of the unqualified.

Fourth, our own ASHA has perhaps the largest role of all in assuming responsibility for professional standards and ethics and for public education. ASHA must of necessity be the unifying and coordinating agency.

Finally, we come to the responsibility of the individual himself. We would hope that our profession would begin to develop such a strong identity that all its members would feel a personal responsibility

for advancing its interests, its acceptance and its prestige. If our training programs have done their work well, we should expect that the young professional person would be turned out for a service career with a built-in identification with the profession and with a built-in pattern of ethical professional behavior, as well as with technical competence.

The duty, then, of developing a responsible profesion does not lie with any group or at any one level alone. It is shared by all the individuals who practice the profession and by all organizations within the profession–local, state and national.

I would like now to turn to something else and discuss briefly some foreseeable trends and problems for the future of speech and hearing services and raise some fundamental questions. Study and planning on all of these are needed immediately.

First and most important of all we can anticipate that the demand for speech and hearing services will increase enormously in the years ahead. The most important factors combining to produce this trend are these:

1. Population growth. If we assume a constant incidence of speech and hearing disorders, the number of individuals needing our services ten or even five years from now will be vastly greater than at present, simply because there will be many more people.
2. We can anticipate an increase in public and professional *awareness* that speech and hearing problems exist and that there are specialists trained to deal with such problems.
3. Closely related to increased awareness is increased *acceptance* of our contributions. Some people who now are aware of our services but don't accept or utilize them will be won over we hope in future years by our demonstration of effectiveness.
4. There is evidence that federal and state agencies are showing increasing concern about speech and hearing problems and are utilizing our services more and more. There is reason to anticipate that this trend will continue.

These factors all combine to show us that we will not be out of business in a few years but that, on the contrary, we will need to get ready for more business than ever.

How can our profession meet the increased demand for services? I would like to suggest a few of the possibilities.

The first one that occurs to us, of course, is a stepped up program of recruitment of more people into the profession. Individually and collectively we must keep this objective in mind constantly, particularly those of us who are in contact with young people at the high school or college level.

Second, we can engage in efforts to secure an increasingly broad base for financial support to speech and hearing services, so that more service will be available to more people in more places.

The great demands of the future, however, cannot be met only in terms of *more–more* specialists and *more* services. We will have to seek other solutions as well as the purely *quantitative* ones.

A third way of meeting increased demands is to seek more effective organization and coordination of the services which exist, to avoid either gaps in service or overlapping and duplication of services. Within every community, particularly the larger ones, coordinated planning about services would stretch even the now existing professional personnel further and make their services more effective.

A fourth promising possibility toward meeting the increased service demands of the future is the exploration of ways in which we could utilize the assistance of others, not specifically trained in speech and hearing. We all recognize the greater effectiveness and rapidity of therapy when it is supported and reinforced by such related personnel as teachers, nurses, physical therapists and others. Let us not overlook, either, the potential help of parents in hastening the therapy process when their help is used appropriately.

In school systems we have been acutely aware for years of the advantages of assistance from classroom teachers. Our much-discussed programs of "speech improvement" in the classroom are a double help to the specialist by handling minor cases and leaving the specialist more time for serious problems, and also by supporting the specialist's therapy so that it will be more rapidly effective. We need to go farther in exploring and experimenting with in-service training programs with parents and colleagues as a means of enabling the specialist in speech and hearing to reach out to more individuals.

Fifth, we can reorganize therapy itself to put greater emphasis on *group methods* rather than individual, again so that more individuals may be served. We have a wide-open field for experimentation in how to make group therapy more effective.

Finally, let us not overlook one of the potentially greatest time and personnel savers of all–the *prevention* of all preventable disorders, through both research and public education. For example, many of us would agree that we have seen the incidence of stuttering drop steadily in the last ten to twenty years. This is probably the result of better understanding by parents and teachers of how the child's

speech develops and what factors disrupt it. Let us contemplate the possibility of what could be accomplished preventively by a concentrated effort at public education.

So much for the problem of meeting increased service demands in the future.

Another problem we must face is a *definition of our ultimate professional goals in service.* We often talk about the inadequacy of present speech and hearing services. But what do we visualize as *adequate* or *optimum* service? Should we not, certainly at the national level of our profession—ASHA—begin to evolve at least tentative service objectives? Do we think in terms of our profession's equivalent of a "chicken in every pot"–a speech or hearing specialist ready at hand to minister to every individual with a disorder? If this is our objective, we must define carefully what we mean by a "speech or hearing specialist" and by a "disorder." Our service objectives must become clearer than they are at present.

Another question concerns the scope of speech and hearing services. Should it be enlarged to take in types of speech and hearing behavior not usually included now? I refer to communication problems usually left at present to others, such as the inhibited child who refuses to talk though she can talk, the adult who feels panic whenever speech is called for in a group situation, the speech of the deaf, the range of geriatric speech problems which we are not touching to any extent now except for an occasional dysphasic. How should we delimit our role in these areas which overlap other professions?

Another question is the future role of ASHA itself in relation to service. Is it proper and desirable for our organization to take initiative in developing services, for example, in geographic areas where services are poor or lacking? How much active promotion should ASHA undertake? Should specific action be taken to initiate services or should we limit ourselves to education of the public and professions and the pointing out of needs? What should ASHA's official role be in regard to control of standards of training and practice? We should be studying and developing policy about these matters.

Dr. Peterson will talk with you shortly about research. I want, though, to mention it briefly in connection with service. We all seem to agree that service and research need each other, but how can this marriage be arranged? What is a feasible relationship between service and research in a world where the pressures for service increase daily? Can research and service competence be embodied in the same individual? Is it not really a question of training all our service people so broadly and deeply that they will perform their clinical functions with a scientific orientation, a lively spirit of inquiry and a habit of objective evaluation? Lack of time to carry out research does not preclude a *research attitude* toward one's service duties.

Another question I would like to raise concerns our present strong trend toward specialization within the field of speech and hearing. Should all speech clinicians be considered competent to handle all types of cases? Or should we encourage people to become specialists in stuttering, specialists in cleft palate, or aphasia, or cerebral palsy or hearing loss in industry? How is this issue of specialization related to level of training? What should be the common core of training for all clinicians? When and how should specialization in training and service begin, assuming we think it should begin at all? The trend is strong toward specialization of services. As a profession we are long overdue for some thought on the implications of specialization for both training and practice.

Another trend we are seeing and one which shows every probability of continuing is the increasing emphasis on the *team approach in service.* It seems likely that as time goes on we will work less and less as completely independent professional experts and more and more as members of a group, sharing diagnostic and therapeutic responsibility coordinately with other professional persons. This seems to be the pattern which is evolving in all modern professional life. Its implications for our training programs are obvious. There may be less obvious but very important policy issues which our profession should study and plan for.

Finally, I would like to raise the question of what changes we can expect in future sources of financial support for speech and hearing services. Through the last 25 years there has been a trend toward increased public support for service, particularly through public schools and state offices of education. In the last few years we have seen more support by federal agencies. Will the trend toward public support continue or will it level off? What part can we expect private philanthropic agencies or service organizations to play in the future? An analysis is needed of the probable financial picture of our services ten and 25 years from now and the implications of this picture for the nature of our services.

Is the public image of the speech and hearing specialist such at present that our professional services would survive a serious economic recession? Are we valued highly enough to be considered essential or are we easily expendable in the public view?

These are problems which merit our attention at once and continuously. Let us not continue to drift semi-consciously as a profession or to let the directing of our course be done by other professions or by chance circumstances. Let us chart now a clear course toward well defined professional goals in service and then steer confidently and energetically toward those goals.

PROSPECTUS OF PROFESSIONAL STATURE: TRAINING

S. RICHARD SILVERMAN*
Central Institute for the Deaf

MY assignment for this afternoon that has been set aside by the Association for collective introspection about our profession is to talk about the preparation of individuals who practice it. I shall attempt to follow the succinctly stated instructions of our program chairman to suggest fundamental concepts that may contribute to the kind of unity that strengthens our practices and that, in turn, inspires confidence in those whom we serve—persons suffering from disorders of communication. The spirit of this occasion precludes detailed, if any, discussion of such specific and important items as the setting for training, academic and professional requirements, length of course, the desirability of good cultural background etc. But I hope that the suggested concepts will stimulate deliberations about these items that will be helpful to those of us who are directly responsible for the creation and management of programs of professional preparation, to those of us who are seeking opportunities for professional growth and development, and to those of related professions.

Let us start by asking what in a general way are the common and essential objectives for preparation for any profession worthy of the label. It seems to me that we need to equip our students with certain fundamental knowledge, with skills that represent an application of that knowledge and with attitudes that encourage the best use of these skills. "Fine," you say, "for other professions but our field is so complex, if not discouragingly amorphous, that these objectives are more easily stated than attained." I disagree. As a profession we are not alone in the kinds of problems (or if you are optimists we shall call them "challenges") of professional preparation that confront us.

REGROUPING AND THE DISCIPLINES

I submit the proposition that knowledge and experience have been accumulating at a rapid and increasingly accelerated pace (and I suppose, for the weary among us at a grimly enervating pace—so much so, that many take refuge in the notion that progress may be achieved by looking forward to days that have passed). If you would seek documentation look about you at the burgeoning libraries, at the fat university catalogs, at the newness of industrial processes and products. A corollary to this proposition is that people tend to regroup themselves around particular constellations of attitudes, knowledge and practices bringing varied but relevant abilities and interests to a problem. An interesting, and for us pointed, illustration of the regrouping phenomenon and its accompanying problems is the situation faced by our universities—particularly as they re-examine their activities in anticipation of the tremendous increase in enrollment in the next two decades. Shall they continue to group around what have now become such traditional academic *disciplines* as physics, biology, psychology, economics, history, anthropology and so forth, which represent certain fundamental bodies of knowledge, and particular ways of arriving at it and communicating it? Or shall they group around *problems* such as labor relations, heart disease, the culture of antiquity, Latin America, or oil? A chemist, equipped with the knowledge and knowledge gathering techniques of chemistry, a discipline, may have a primary interest in oil, a problem. In satisfying this interest professionally, he finds himself relating to market analysis, automotive engineering, geology and other varying combinations of disciplines and problems.

Charles V. Kidd in his "American Universities and Federal Research"[1] calls the regrouping trend to our attention in the administration of research funds, a subject of increasing importance to our profession. "The problems arising in the search for a workable relation could be solved by the (government) agencies, the universities, or the National Research Council. But the machinery that actually has been invented and adapted for the task is the scientific advisory group. Made up largely of scientists from universities, the advisory group is a new means for deciding whose research will be financed in universities. Many decisions formerly made within single universities have been transferred to faculty members from many universities regrouped by discipline or by research problem. This method of arriving at decisions, which was almost a prerequisite to the successful operation of the system, has shifted important

S. RICHARD SILVERMAN, Ph.D. is Director of the Central Institute for the Deaf, and Professor of Audiology, at the Washington University Graduate School and The Medical School, St. Louis, Missouri.

*Presented at a general meeting on "What is our Association?" at the 1959 Convention of the American Speech and Hearing Association.

powers of decision from federal administrators and from universities."

The rapidity with which our knowledge and our accompanying sense of responsibility are increasing has resulted at best (as we see here this afternoon) in challenging us to re-examine the way we approach our regrouping in such matters as societies, journals, curricula, patterns of service, financial support and, at worst, in jurisdictional irritations, if not disputes, as we search for ways to group ourselves. The important *problem* for us, disorders of communication, has avoided neither the virtues nor the vicissitudes of the regrouping phenomenon. I am encouraged when I think, for example, of an area in which a good deal of my daily teaching is concentrated, the education of deaf children. Professional performance has been enhanced and improved by the contributions of relevant disciplines. But the area has not achieved its potential progress because of the difficulties, real and imagined, of regrouping. The banal epithets "faddist," "theorist," on the one hand and "old-fashioned," "unscientific," on the other hardly worthy of mature thinking, are none the less handy and useful for those who out of ignorance, intransigence, inertia or insecurity fear the encroachments of those who may not wear the old school tie (or any tie for that matter). Some encroachers may, after all, be scientific Greeks bearing clinical gifts and need to be resisted.

I believe that intelligent, considered regrouping around the problem of communicative disorders is essential and attainable. This regrouping should not be the exclusive concern of those for whom it may indicate some kind of formal action. Rather, it should infuse the thinking of all of us and the practices that result from it. Furthermore, it must rest on our recognition of the potentially rich contributions of certain basic disciplines and significant areas of activity. Important among these are:

1. Physics because it is concerned with the measurement and description of sound, light and vibration and contributes to the understanding of body mechanics as they relate to the act of speech and hearing.
2. Biology because it is concerned with the organism in sickness and health and, in our case, the organism deprived of certain abilities.
3. Psychology because it is concerned with the interaction between the stimulus and the organism. A simple audiometric test, for example, rests on important psychophysical principles and assumptions. And a therapeutic session in the speech clinic may be effective to the extent that it recognizes certain principles of reinforcement of behavior.
4. Education because it is concerned with modification and direction of behavior. And much of our work is carried on in a school context.
5. Anthropology-sociology because it is concerned with the development and analysis of cultural patterns. For example, the evolution of language itself is of prime significance for us. And we must not overlook the need to think about the attitude of society toward individuals with handicaps.

From what I have been saying it is obvious too that we need to be sensitive also to the various combinations of these disciplines and areas of activity. And persons who are not engaged in a direct service profession are interrelating activities among the disciplines. Biophysics and psychobiology are increasingly familiar groupings in the pursuit of knowledge.

PROFESSIONAL SERVICES AND THE DISCIPLINES

Even this necessarily brief and undoubtedly incomplete listing constitutes a formidable array of basic knowledge and related activity. Some of us may be overawed by it. We need not be (and by *we* I mean here those individuals who render direct service to the speech, hearing and language handicapped person, call us teachers, clinicians, or what you will) because we are both producers and consumers. To expect that we shall be producers in all of these areas is neither realistic nor necessary. It seems to me that our task is to be producers in the area to which we have committed and professed ourselves and that is in the area of prevention, discovery, assessment and treatment of persons whose social efficiency is impaired by disorders of speech, hearing and language. Our contribution consists of applying knowledge that is relevant to this purpose. Of course, many of us may develop competence in more than one of these disciplines and activities. Our never ending task, then, is to shop discriminatingly and efficiently for raw materials in the market place of the disciplines and to fashion them into increasingly improving tools that enable us to accomplish our professional mission. In turn it is our obligation to acquaint the producers of raw materials with our abundant experience and our needs so they will be stimulated to prospect for more and better materials. This process of synthesizing relevant ideas and knowledge into professionally applied skills is the core of our profession and, I submit, its unifying concept.

I said before that a profession needs to be concerned with knowledge and skills and the attitudes that encourage their acquisition and best use. The creation and nurture of desirable attitudes in professional practitioners is a difficult task. Perhaps our success in this regard may be conditioned by our

process of selections of students in the first place. In any event we should have the wisdom to create an atmosphere where students experience respect and understanding for competence, for professional integrity, for individual worth, for differences of opinion, for courage in the face of frequent disappointments that inevitably accompany work with the handicapped, for pursuit of new knowledge and skills and for compassion towards impaired human beings.

GUIDING PRINCIPLES IN LEARNING TO SERVE

I recommend some guide lines for exploring ways to give expression to the concepts I have suggested.

1. We reject the assumption that everything that is learned must be taught. Learning must go on beyond our days on the campus and it takes place in many ways, frequently without formal contrivance. It is, therefore, essential that in the course of professional preparation we equip our students with experiences that are generative of new growth and not terminal. We need to learn to learn. We need to stop thinking exclusively about training people for our profession and begin to concentrate on educating them for it. Of course, our students need to learn techniques and devices for the clinic and the classroom but we must not let our enchantment with the immediate and the practical overwhelm us completely. In the course of learning on our own we, as practioners, ought to sense and to fulfill independently the responsibility to improve techniques and not always to be dependent on "taking a course." Without this attitude we contribute to the stagnation of technique itself. On this point I cite and partially paraphrase C. Wright Mills who says in his recently published "The Sociological Imagination,"[2] "He (the professor) must proceed in such a way and with such materials as to enable the student to gain increasingly rational insight into these concerns (about his profession) and into others he will acquire in the process of his education. And the educator must try to develop men and women who can and will by themselves continue what he has begun; the end product of any liberating education (and preparation for a profession) is simply the self-educating, self-cultivating man and woman."

2. We must plan for achieving different levels of competence that apply to kinds and severity of disorders. This principle is characteristic of many service professions and it suggests that our practitioners will need to recognize when their competence is not sufficient for a particular problem. They will need to know when to seek consultation of specialists and when to refer persons to others. Furthermore, particularly in matters of medical concern, they will be apprised of the limitations on their professional practice.

3. Professional skill is the ultimate commodity in which we deal. Therefore, there must be ample opportunity both during and after the period of formal preparation for students and workers to observe skilled practitioners and to have an opportunity to practice under their supervision. Guided practice needs to encompass varied clinical and educational types and must be intense and continuous. If the opportunities for this are not available within the institution we must reach out for them to hospitals, rehabilitation centers, schools for the deaf and public school systems. Text books and rigid didacticism, the conventional pedagogical tools of the campus, are not sufficient by themselves to fashion professional skills. Medical schools and their teaching hospitals have set us a good pattern in this regard.

4. The basic course of professional preparation should be a unified whole. Acquisition of professional skills should not be a matter of garnering here and there and now and then credit hours that are frequently either unrelated or distressingly redundant. These skills should result from an orderly, uninterrupted, logically sequential set of experiences that lead from fundamental knowledge to practice. Perhaps undue emphasis on accumulation of credit hours is encouraged by dependence of certifying bodies within and outside of the profession on the credit hour as a major index of professional competence. Scrutiny of the patterns of schools of medicine may be helpful to us.

5. Evaluation of the philosophy, structure and content of professional preparation should be continuous. We should not permit minimal standards set by certifying bodies to stultify our curricula and to discourage experimentation and innovation. From my experience as a teacher in a professional program, as an employer of teachers and clinicians, as an examiner for a certifying body and as an advisor on national policies for professional training I am mindful of the difficulties that confront us in evaluating programs and individuals. Here, too, we are not alone. A quick look at the situation in the evaluation of teacher education on which the Fund for the Advancement of Education of the Ford Foundation has spent huge sums of money

demonstrates this. Paul Woodring, reporting for the Fund, says in his Monograph "New Directions in Teacher Education,"[3] "In appraising these evaluative studies it is important to keep in mind the fact that more traditional patterns of teacher education have rarely been the subject of definitive evaluation and this lack makes any comparison difficult. We have never known with any certainty how liberal, specialized or professional education affects a teacher's classroom performance. Despite the existence of strongly held opinions we do not really know how graduates of liberal arts colleges compare, as teachers, with graduates of teachers colleges. We do not really know just how practice teaching, in its conventional form, has contributed to teaching success or how many and what kind of professional courses are really justified in terms of their long range influence on the teachers' performance in the classroom." I would suggest that our continuing evaluation be carried on to some extent, at least, *by men and women of ideas without immediate power or responsibility* and not solely by official representatives, as is too often the case, of special interest groups who bring to this tough problem only the organizational party line.

6. Our main credential to allied professions should be a level and kind of competence that is unique to our profession. Upgrading of acceptance by and relations with other professions is not accomplished by changing the labels we place on our activities or the titles we attach to ourselves. Of course, these labels and titles must be as descriptive as possible but they must also stand for competence that is readily recognized and consequently sought and valued.

In summary, I have said:

1. Our profession needs to equip our students with certain fundamental knowledge, with skills that represent an application of that knowledge and with attitudes that encourage the best use of these skills.

2. Knowledge and experience have been accumulating rapidly. This accumulation is accompanied by regrouping of individuals from various disciplines and areas of activity around problems of common interest.

3. Our grouping is around problems of disorders of speech, hearing and language and our effort is nurtured by physics, biology, psychology, education and anthropology-sociology and various combinations of these. The unifying concept of our profession is the process of synthesizing relevant ideas and knowledge from these areas into professional skills.

4. I have suggested some guide lines for exploring ways to give expression to these concepts: a) everything that is learned must not be formally taught, b) we must plan to produce varying levels of competence, c) professional skill is the ultimate commodity in which we deal, d) the basic course of professional preparation should be a unified whole, e) evaluation of professional preparation should be continuous, f) our main credential to allied professions is a level and kind of competence that is unique to our profession.

I cannot resist concluding with the time honored but, I believe, valid observation that the ability to communicate and to understand ideas by speech and hearing is one of the basic socializing influences among human beings. When it is disordered the need for help may be crucial for psychological, social and economic self-realization, if not survival, of the affected individual. Our calling is, therefore, significant and ennobling. I trust that among us there is the urge to meet its complex problems with wisdom and with vigor to the end that we shall wear its mantle with dignity and that we shall be worthy of its challenge.

References

1. Kidd, C. V. *American Universities and Federal Research.* Boston: Belknap Press, Harvard Univ. Press.
2. Mills, C. W. *The Sociological Imagination.* New York: Oxford Univ. Press, 1959.
3. Woodring, P. *New Directions in Teacher Education.* New York: Fund for the Advancement of Education, 1957.

Legislation

FRAMPTON STUDY WORKSHOP–ELLIOT SUBCOMMITTEE HEARINGS NEW ENGLAND*

The second in a series of Workshops conducted by the United States House of Representatives, Subcommittee on Special Education and Rehabilitation was held at Yale University, New Haven, Connecticut on December 15-16, 1959.

The purpose of this Workshop was to identify the needs in the areas of special education and rehabilitation in New England and to obtain recommendations for Federal legislation to meet these needs. The Workshop was divided into seven areas dealing with the problems of special education and rehabilitation, one of which was Speech and Hearing. Co-Chairmen selected for the Speech and Hearing Section were Dr. Geraldine Garrison, Supervisor of Speech and Hearing Services, Connecticut State Department of Education and Dr. Albert T. Murphy, Professor of Speech Pathology and Audiology, Boston University. The Co-Recorders selected for these sessions were William A. Philbrick, Jr., Supervisor of Speech Handicapped, Hard of Hearing and Deaf, Department of Education, Commonwealth of Massachusetts and Dr. Wilbert L. Pronovost, Director, Speech and Hearing Center, Boston University.

Thirty-Two professional workers in the fields of speech and hearing representing six New England states were invited to participate in the Workshop proceedings. The participants remained intact for total group discussions following which a report of unanimously agreed upon findings and recommendations was prepared by the Co-Chairman and the Co-Recorders.

On December 17, 1959, the day following the final Workshop date, the report of the Speech and Hearing Workshop Section was presented at a special hearing held by the Subcommittee on Special Education and Rehabilitation of the United States House of Representatives at the United States Post Office Building in New Haven, Connecticut.

The report of the Workshop findings and recommendations as presented to the Subcommittee on Special Education and Rehabilitation of the United States House of Representatives follows.

NEED FOR SPEECH AND HEARING SERVICES THROUGHOUT NEW ENGLAND

Using the 1950 White House Conference prediction that 5% of the school population can be expected to have speech and/or hearing handicaps, the following report is an indication of the need for speech and hearing services throughout New England.

INCIDENCE

There is a great need for intensive research to identify the types and geographical distribution of speech and hearing problems and deafness. This need implies the necessity of whole-hearted cooperation among schools and agencies of all kinds to accomplish the desired result. The problems involved in determining incidence are as follows:

1. Lack of standardized criteria to delimit types of problems.
2. Listing minor degrees of problems as major.
3. Geographical location of speech or hearing handicapped persons.
4. Degrees of training of persons in diagnostic or educational centers.

CONNECTICUT 1959-1960

Twenty-two thousand, eight-hundred and eighty-five children in the Connecticut public schools have speech and hearing problems.

Thirty-five percent, or approximately 8,000 children are now receiving speech and hearing treatment in the Connecticut public schools.

Sixty-five percent or 14,875 could benefit were such services available to them.

Eighty speech clinicians now provide services for the 8,000 children.

Based on the ratio of 100 children to each clinician, 150 additional speech clinicians would be needed to provide services for the 14,875 children.

Ten additional speech clinicians would be needed to meet the speech needs of the mentally retarded children in the state.

Thus, 160 additional speech clinicians would be needed in the Connecticut public school system to

*Prepared by ALBERT T. MURPHY, Ph.D., Boston University, in cooperation with GERALDINE HARRISON, Ed.D., Connecticut State Department of Education, WILLIAM A. PHILBRICK, Jr., M.Ed., Massachusetts Department of Education, and WILBERT L. PRONOVOST, Ph.D., Boston University.

meet the needs of the speech and hearing handicapped population.

This does not include the 3,965 children who could benefit from speech and hearing services were such services available in the parochial schools. An additional 40 speech clinicians would be needed to work with these children.

Fourteen positions are now unfilled as a result of resignations.

Only four speech clinicians entering the Connecticut school system in September 1959 were trained in the state of Connecticut.

CONNECTICUT 1965-1966

Five thousand, seven hundred and sixty-seven children will need speech and hearing services in 1965.

Fifty-eight additional speech clinicians will be needed to work with these 5,767 children in 1965.

Twenty additional speech clinicians will be needed to work with the mentally retarded children in Connecticut in 1965.

Thus, 318 speech clinicians will be needed in Connecticut public schools in 1965.

Seventy additional speech clinicians will be needed in the Connecticut parochial schools in 1965.

Therefore, a total of 388 speech clinicians will be needed in Connecticut's public and parochial school systems in 1965. This is 308 more speech clinicians than in 1959.

SCHOOL FOR THE DEAF 1959-1960

There has been a 64% increase in enrollment at one school for the deaf (Mystic) during the past six years. The present enrollment numbers 139 children.

Nine classroom teachers are needed now and cannot be located.

Four special teachers including a supervising teacher, librarian and two physical education teachers are needed now.

Two house mothers are needed to maintain a ratio of one house mother to each 10 children.

One audiologist is needed for hearing evaluation of pupils upon admission and for systematic re-testing as well as for advice in the selection of hearing aids.

One psychologist is needed for adequate psychological testing.

MASSACHUSETTS 1959-1960

Fifty thousand children in the Massachusetts public schools have speech and hearing problems.

Thirty-four percent or approximately 17,200 children are now receiving speech and hearing therapy in the Massachusetts public schools.

Sixty-six percent or 32,800 children could benefit from treatment if such services were available to them.

One hundred speech clinicians now provide the services for the 17,200 children.

Based on the ratio of 100 children to each clinician, 320 additional speech clinicians are needed now to meet the needs of the 17,200 children with speech and hearing problems.

Ninety speech clinicians are needed to meet the needs of the educable mentally retarded children in the state.

Thus, 410 additional speech clinicians are needed now in the Massachusetts public schools. This does not include the more than 5,000 parochial school children who are also in need of these services.

MASSACHUSETTS 1965-1966

Twelve thousand, five hundred children will need speech and hearing services.

One hundred twenty-five additional speech clinicians will be needed to provide these services.

Twenty-five additional speech clinicians will be needed for the mentally retarded population.

Thus, 660 speech clinicians will be needed in the Massachusetts public shools in 1965.

SCHOOLS FOR THE DEAF

Six-hundred seventeen Massachusetts children are presently attending residential schools, day schools or day classes for the deaf. These children attend the Beverly, Boston and Clarke Schools for the Deaf, residential schools; the Horace Mann School, day school; six day classes in public schools; the Rhode Island School for the Deaf in Providence, Rhode Island; Austine School in Brattleboro, Vermont and the American School for the Deaf in Hartford, Connecticut.

TABLE I

State	Children Needing Services 1959-60	Clinicians Needed 1959-60	Inc. in Cases 1965	Extra Clinicians Needed 1965
Maine	9500	95	2380	24
Vermont	3700	37	925	9
N. H.	5650	57	1450	15

OTHER NEW ENGLAND STATES

Table I indicates the numbers of children needing speech and hearing services in Maine, Vermont and New Hampshire at the present time as well as the number of speech clinicians needed to meet these services. Estimates of the increase in cases as well as the increased number of speech clinicians needed in 1965 are also indicated.

A great deal of the work in these states and in Massachusetts, Rhode Island and Connecticut towns of less than 5,000 population will have to be accomplished on a regional basis.

The above figures do not take into account all the clinical, hospital, college, university and private practice speech and hearing clinicians needed in the New England states.

KINDS AND EXTENT OF SERVICES AND FACILITIES NEEDED

The following section of the report discusses the kinds and extent of services and facilities urgently needed for diagnoses, educational programs, clinical programs and guidance programs for parents and adults.

A. Massachusetts, Maine, New Hampshire and Vermont need state reimbursement programs for speech and hearing services in the public schools.

B. Private schools need Federal aid for speech and hearing programs.

C. Approximately 50% of the mentally retarded children in the New England states need speech and hearing services.

D. Different states have different needs. This implies the need for a coordinating body or individual in each state as well as for the whole region. In the case of rural areas, services may need to be coordinated across state lines.

E. A regional diagnostic, education and treatment center for the child with a complicated language disturbance is urgently needed. The cleft palate team at Tufts needs to be duplicated or to travel. Possibly, pilot programs are needed for selected groups such as pre-school or in the area of geriatrics.

F. The public school's own teams can do diagnosis and treatment with many handicapped children and should be encouraged to do more. In meeting the needs of the child with severe multiple handicaps, the services of related specialists in the community and state should be utilized.

G. Intensification of pre-school diagnostic and treatment facilities, the means of home counseling, the use of written material for parents and children, and the extension of social work services to these families should be undertaken. Pilot nursery school programs should be established. Increased guidance services should be made available to the adolescent and adult speech and hearing handicapped population.

Federal funds should be made available to assist in the creation of units similar to the Sarah Fuller Foundation, sending trained teachers of the deaf into homes of hearing handicapped infants to help the parents understand the problem and when appropriate to begin the teaching of language and communication to the child.

H. Provision must be made for family followup work by school social workers and guidance workers.

I. Funds to facilitate better screening of speech and hearing handicapped infants by providing grants for training of pertinent personnel is urged.

J. Federal funds are needed to conduct two annual six-week workshops to upgrade personnel presently functioning in speech and hearing services and in the education of the deaf. These workshops would serve 25 to 30 persons from the region and cost approximately $30,000 each.

K. Summer school speech and hearing programs conducted at the local or regional level are needed for children with severe speech and hearing difficulties in public and parochial schools. Summer day and residential camps could meet the educational and social needs of the speech handicapped, hard of hearing and deaf children, if funds were provided.

L. Speech and hearing personnel in the Office of Vocational Rehabilitation and State Departments should be amplified.

M. Education, information and reciprocal assistance must be effected with guidance personnel, psychologists, medical personnel, nurses and other allied professional workers by means of institutes, workshops, and conferences.

N. Federal assistance is necessary to increase existing physical plants because of the pressure of increasing case loads, required personnel and new equipment needs.

O. The following procedures are necessary to meet the problem of facilities for the speech and hearing handicapped population as well as deaf persons in the rural areas.

1. Federal funds should be made available to departments of education to launch intensive information campaigns to create an awareness of the existing problems and the assistance needed.
2. There is a need for utilization of summer camps for speech and hearing handicapped or deaf persons to demonstrate the size of the problem and the techniques for coping with it.
3. Federal assistance should be given to create regional school speech and hearing programs as well as regional diagnostic, educational and treatment centers.
4. Federal funds should be given for transportation, board diagnostic and therapeutic fees for children and adults who visit regional diagnostic medical centers for speech and hearing examinations.
5. The pooling of speech and hearing resources with those of other rehabilitation and educational facilities to create centers offering wide services is most imperative.
6. Federal funds are needed to explore the feasability of and provide materials for:
   a. Utilization of Homemakers Extension Services in State Departments of Agriculture, Grange organizations, Farm Bureau, 4-H clubs and other farm community clubs to publicize the existence of speech

handicaps, hearing loss and deafness and to educate the rural population in the types of diagnostic and therapeutic services indicated.

b. Requesting assistance of the Visiting Nurses Associations for similar informational purposes and by providing mobile testing units and recording units at County Fairs to spread awareness of the existence of the facilities available and the need for increased facilities.

P. There should be an extension and amplification of services to the homebound by providing fees for speech and language retraining of adult aphasics at home or in nursing homes.

Q. There is a need for more extensive services and assistance to speech handicapped, hard of hearing and deaf persons through State Rehabilitation Offices. Prostheses for cleft palate persons and hearing aids for hearing handicapped should be supplied at minimal costs by the government.

R. If funds could be made available to employ an instructor, methods and techniques for preparing persons now doing pure tone screening testing to do pure tone threshold hearing testing together with information on hearing conservation could be provided through a concentrated two to three week workshop held in different sections of the state. An estimated 300 school nurses and other professional persons would attend these workshops. The workshops could be conducted in a local school, a school for the deaf, a state college or university at a nominal cost. The benefit to children with suspected hearing losses would be of great significance in both time and money.

PERSONNEL AND TRAINING FACILITIES

There is a great need to increase the training facilities for clinicians in the field of speech handicapped, hard of hearing and the deaf. This necessitates the amplification of staff and facilities in training centers as well as scholarships, fellowships and the upgrading of present personnel.

There are now 193 speech and hearing clinicians in the public schools of New England. On the nationally accepted incidence figure of 5% of the school population having speech and hearing problems and the nationally accepted ideal of one speech and hearing clinician per 100 children, we actually need 1027 speech and hearing clinicians to serve all the speech and handicapped needing help. We desperately need at least 260 of the 1027 clinicians immediately.

The Office of Vocational Rehabilitation has estimated that for the pre-school and adult populations (school population excepted), one speech pathologist per 50,000 persons is required. On this basis, New England needs 200 such speech pathologists at this moment in its hospitals, clinics and private agencies, but has no more than 50. At least 50 more of the ideal 200 are needed immediately. By the same estimate, 200 audiologists are needed and 50 additional audiologists are needed immediately.

At this moment, four New England teachers are training for the deaf at Clarke School. Ten graduate students in speech and hearing will soon graduate from South Connecticut College. Eighteen students will graduate in June from Boston University. Thirty students will graduate in June from Emerson College. Seven students will graduate in June from the University of Connecticut. Some of these students, in all probability, will not remain in New England as they are from other areas in the country.

These small numbers (4 teachers of the deaf and 65 speech and hearing clinicians) indicate an overwhelming need for a concentrated recruitment program. The American Speech and Hearing Association should be given a Federal grant to undertake a national recruiting program in the fields of speech and hearing. This program should involve an information program, public relations program and an organized drive for upgrading of present personnel.

The increase in numbers of clinicians and teachers of the deaf would require more supervision which would involve increased staffs and increased expenses. Federal assistance is badly needed in this area.

The numbers of hospitals, clinics and private agency positions requiring the specialized services of speech pathologists and audiologists indicate the need of expanding training programs qualified to train people to this high level. The course requirements, necessary staff, equipment and supervision would necessitate double or triple the personnel and budgets being obtained at the present time by training institutions.

There are no audiologists being trained, at this moment, anywhere in New England. The gravity of this situation cannot be overemphasized.

The present crippling case loads being borne by speech and hearing clinicians in most parts of New England probably preclude the possibility of really successful treatment with most of their cases. This overwhelming amount of work may also cause young clinicians to leave the profession.

There is a great need for Federal aid in the form of reimbursement for part of the salary of new personnel in speech and hearing and education of the deaf at the state level, in public or private schools, hospitals or clinics or in the form of reimbursement for expansion of existing programs of speech and hearing or education of the deaf.

There is needed a minimum of $500,000 annually for five years in the form of grants-in-aid and fellowships to expand existing training programs and to facilitate the creation of new training programs in the fields of speech and hearing and education of the deaf.

The present lengthy practicum requirements of one residential year for teachers of the deaf, and the growing tendency to increase the length of practicum programs in speech and hearing which implies the need of five and six year training programs indicates clearly the need for Federal funds to facilitate the assumption of such practicum programs by students in speech and hearing and the education of the deaf.

The Federal government should re-scrutinize the provisions of the Social Security Act of 1936 relating to assistance to persons in depressed, rural areas. In many cases today, the population explosion has carried the better class into the rural areas, thus raising this socio-economic level, and has left the city a much depressed area. New lines and provisions must be drawn to take cognizance of this shift.

Funds should be available for persons in local or state supervisory positions in schools, hospitals, clinics, or agencies to pursue such extra training as will bring them the advanced certification befitting their responsibilities.

RESEARCH NEEDS

The need for continued research studies in the fields of speech and hearing is great. Several of our more immediate research needs are:

1. Incidence studies by type, age and geographical distribution of the speech and hearing handicapped population.
2. Comparison of educational and treatment approaches especially for the retarded and physically handicapped.
3. Studies on adolescent speech and hearing problems. A barren area of research.
4. Analysis of the transition between school and the work of the speech-and-hearing handicapped. The correlation between guidance personnel and rehabilitation agencies working in the area of speech and hearing services.
5. Value of temporary sheltered employment and treatment for persons with severe speech or hearing handicaps.
6. Better prognostic methods with adults having severe speech and hearing handicaps.
7. A study of the kinds of facilities best adapted to rural versus urban population.
8. Need of laboratories to study the psychophysics of audition and the speaking process.

Had your Audiometer Calibrated Lately?

Time will tell on your audiometer. It loses its precision. Earphones change. If you want *accuracy* in your measurements of hearing loss, *your audiometer must be calibrated every year!*

The Allison Audiometer Calibration Unit is the only equipment of this type available that will measure both the acoustic output level on the earphone and loss of the attenuator over its full range.

And it sells for less than many complicated "artificial ears."

Model 300C Auxiliary Amplifier for noise level and sound field measurements. Adds 30 db gain; allows measurements to be made to below 40 db. Price: $95.00. Also available: 2CC Coupler Adapter to fit the NBS9A Coupler; $15.00.

Allison Series 21 Audiometer... the complete audiometer. Two-channel systems, designed for two room installation. Warble tone masking signal. Binaural hearing aid evaluation tests. Sound field audiograms. Delayed speech feedback. Six models; prices start at $3,775.00.

FEATURES OF THE ALLISON AUDIOMETER CALIBRATION UNIT MODEL 300

- **Checks accuracy of attenuator at all frequencies to −10 db**
- **Earphone acoustic output measurements made at all frequencies down to 60 db**
- **Complete instruction book helps you check calibration on your own audiometer**
- **Case size: 15½" x 9" x 7⅛"; weight: 11 pounds**
- **Price: $825.00**

Proved dependable in years of service

ALLISON LABS.

Write for Engineering Bulletin with complete technical data.

Allison Laboratories, Inc.

11301 Ocean Avenue La Habra, California

Developed for the Profession

Now... from Otarion

a top quality new combination speech and pure tone AUDIOMETER

at the introductory price of

only $550.00

"All that is to be desired in the office"

—says noted otologist—

Imagine, a combination speech and pure tone Audiometer with all these features in one attractive light weight case:

- A pure tone circuit from 250 to 8,000 cycles with continuous tone and pulsating tone
- Speech circuit with high suppressed, low suppressed and normal positions
- Speech circuit and record circuit
- Masking circuit and microphone circuit
- In-built loud speaker plus jack for external speaker
- Double high quality earphones
- Bone conduction receiver
- Microphone and Monitor phone

The Otarion Model 1000 Speech and Pure Tone Audiometer was specifically developed to provide the most complete testing equipment in one convenient unit. And the special introductory price of $550.00 includes all the "extras" necessary for both diagnostic and prescription purposes. Write today for full information. The Otarion Model 1000 is available either in cabinet or portable models.

Gray Plastic Covered Portable Case

Developed by Otarion engineers who created the world's first (and best) eyeglass hearing aid, The Listener.

Otarion Listener CORPORATION

Ossining, New York

SERVING THE HARD OF HEARING SINCE THE 1930's

OTARION LISTENER CORP.
Ossining 25, New York

PLEASE SEND complete information on the Model 1000 Audiometer.

Name_____

Address_____

City_____ State_____

State Associations

HOUSE OF STATE DELEGATES: APPLICATION POLICY

During 1959, the American Speech and Hearing Association's National Office was contacted by a number of different states concerning information regarding "affiliation" in the House of State Delegates. Correspondence was received from representatives in the following states: Alabama, California, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Missouri, Montana, Nebraska, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia and Washington. A few of these state groups made formal application for affiliation. Most groups merely raised questions concerning necessary By-Law changes and the procedures to follow to become "affiliated."

Several problems were encountered in the preliminary evaluation periods. These problems were in the areas of: discriminatory membership requirements, discriminatory names, lack of ethical codes, restricted interest areas and lack of independent organizational structure.

1. *Discriminatory Membership Requirements:* Problems encountered revolved around the restriction of membership to "therapists" or "speech correctionists" without adequate provision for audiologists, personnel in research activities, or persons not holding certification by ASHA or the State Board of Education. Another problem brought to focus was the fact that qualification for membership in some state groups was dependent in part, on the requirements of a third party. For example, certification by a State Board of Education brought automatic qualification for membership in some state associations.

2. *Discriminatory Names:* It was noted that several states implied through association names restrictions of interest and membership. This was exemplified in such names as "State Speech Correction Association" or "State Speech and Hearing Therapy Association."

3. *Code of Ethics:* It was noted that many of the state groups applying did not have a written Code of Ethics.

4. *Restricted Interest Areas:* The purposes for which some of the organizations were formed did not, in some instances, include those people with research interests or interests in audiology.

5. *Lack of Independent Organizational Structure:* Several state associations applying for "affiliation" were divisions of some larger association and possibly subject to the influences of groups with nonparallel interests.

As a result of the problems encountered and in an attempt to allow the "affiliation" procedures to move as smoothly as possible, a series of Procedures and Principles were established and approved by the Executive Council.

PROCEDURES

1. A formal letter in triplicate is requested from a responsible official stating that the *responsible group* (whether council or voting membership, depending on the By-Laws) in the state association requests recognition ("affiliation") from the ASHA as being eligible to send a delegate(s) to the House of State Delegates.

2. Three copies of a current accurate membership list are requested. These lists are to be accompanied by some indication of which state association members are also ASHA members.

3. Three copies of the current Constitution and By-Laws are requested.

PRINCIPLES FOLLOWED IN EVALUATING CONSTITUTION

1. The name of the state association should be appropriate for the total membership of ASHA.

2. The membership requirements should be essentially the same as those of ASHA.

3. Ethical practice requirements should be stated and should be compatible with those of ASHA.

4. Some provision should exist for the election or appointment of a delegate(s).

5. The organization making application should be representative of the broad membership and interests of ASHA in the state.

6. The organization making application should be a state speech and hearing association and not a division or department of another larger state association.

7. Membership requirements should not be stated in terms of requirements controlled by some other organization.

8. Membership in the state speech and hearing association should not be related to membership in any other group or organization (including ASHA).

CONVENTION MEETING

A meeting was held during the recent convention in Cleveland of the representatives of all the state groups that had contacted the National Office during 1959. There appeared to be unanimous acceptance of the procedures and principles presented by the Executive Council by the representatives of the seventeen states in attendance. Following is a list of the members in attendance at this special convention meeting:

Alabama	Ollie Backus
Colorado	Ruth M. Clark
Florida	D. Kenneth Wilson
Indiana	Marian Donewald
Iowa	Dale Bingham Carl Betts
Kentucky	Charles F. Diehl
Maryland	Margaret Falk
Michigan	Ruth G. Curtis A. Bruce Graham Mary S. Kennedy Keith L. Maxwell
Missouri	Robert Goldstein
Ohio	Loraine A. Wilson
Oklahoma	Thayne A. Hedges
Pennsylvania	George H. Shames
Tennessee	Jean Gilford Forest Hull
Texas	Lennart L. Kopra
Utah	Wallace A. Goates
Virginia	James M. Mullendore Libby Radus
Wisconsin	Gretchen M. Phair Thad F. Paruzynski Marjorie Vesley Rhoda E. Zucker

All applications for "affiliation" as well as questions pertaining to the "affiliation" process should be directed to the National Office. The National Office will make itself available to representatives of all state groups to assist in making suggestions for proposed changes in constitutional structure and By-Laws. The Executive Council will take immediate action on all applications as they are submitted throughout the year.

The applications of two State Speech and Hearing Associations have been approved to date, the States of Kentucky and Iowa. The first meeting of the House of State Delegates is scheduled to take place at the 1960 Convenion in Los Angeles.

S. L. B.

IOWA SPEECH AND HEARING ASSOCIATION

Application Approved For

HOUSE OF STATE DELEGATES

THE ASHA Executive Council approved the application of the Iowa Speech and Hearing Association in February, 1959. The ISHA has 114 members having voting privileges, 67 of whom are members of the American Speech and Hearing Association. The Officers of ISHA are:

President:	Dale Bingham
President-Elect:	William K. Ikes
Secretary-Treasurer:	Irma Rice
Editor:	Barbara Murray

Another Sonotone first...

Automatic Volume Control (AVC) softens loud, disturbing sounds—delivers clearer, more comfortable hearing

Automatic Volume Control in Sonotone's latest hearing aids automatically suppresses overly loud sounds, yet makes even very soft sounds clearly audible. This means more comfortable, controlled hearing all the time.

An AVC-equipped Sonotone hearing aid acts as a sensitive "monitor." It automatically compensates for changes in sound volume, much as normal ears do. The tremendous dynamic range of sound is compressed into the more limited range of intensities afforded by most perceptively deafened ears.

To help correct the many different types and degrees of hearing loss, Sonotone offers herewith a variety of hearing aid models—each equipped with AVC—each designed to provide the greatest possible hearing benefit.

MODELS "77," "88," "99" employ the same electronic chassis but differ in the overall size of their cases to accommodate different battery combinations. Thus the different models are capable of different maximum output volume levels. These range from 125 db for the Model "77" to 138 db for the Model "99." Gain of the three models is 62, 70 and 71 db, respectively.

There is one model for every degree of hearing loss from mild to severe. In addition, each model provides 9 power and 6 tone settings for maximum flexibility in adjusting it to the specific needs of the individual user. These models are compact and economical. With symmetrical peak clipping, they provide outstanding speech reception even when operated at maximum output.

MODEL "410"—fashionable, powerful, individually-fitted eyeglass hearing aid. The "410" conforms to the latest slim-line fashions in eyeglasses—gives powerful, medically-preferred binaural hearing. And, while wearing his own lenses and fronts, the "410" user has his hearing aid glasses expertly fitted to his own contours.

Sonotone CORP.

A Lifetime Program for Better Hearing!

ELMSFORD, NEW YORK

News and Announcements

SPECIAL NOTICE

JACK BANGS, Ph.D., Vice-President of ASHA and Chairman of the Committee on Program for the 1960 Convention announces that a large SCIENTIFIC EXHIBIT will be held at the Los Angeles Convention. Awards will be made for the outstanding exhibits. Application forms may be obtained by writing: Executive Secretary, American Speech and Hearing Association, 1001 Connecticut, Washington 6, D. C.

Organizational

A Congress of the International Audiology Society will be held in Bonn, Federal Republic (West Germany), September 28-October 1, 1960. Three roundtable discussions will be featured: 1) "The auditive cortical function and related disorders in adults and children" 2) "Physiology, functional pathology and the clinical significance of recruitment" and 3) "Adaptation and related visible deformities and their clinical significance." Professor Luscher of Basel, Switzerland, is president of the Society. Further information can be obtained from De Trenque, Executive Secretary, 4 Rue Montvert, Lyon, France.

United Cerebral Palsy has available reprints of an article, "Suggestions for the Adaptive Administration of Intelligence Tests for those with Cerebral Palsy" by Robert M. Allen, Ph.D., and Marjorie Collins. Ph.D. Also, available is a bibliography, "Selected Books on Cerebral Palsy."

A booklet which decribes the necessity of prompt diagnosis and early treatment of "little" strokes to avoid more serious paralyzing attacks, is available from the United States Public Health Service. The pamphlet, *Little Strokes—Hope Through Research*, was prepared by the National Institute of Neurological Diseases and Blindness. An optimistic view is presented, but the importance of proper treatment, rehabilitation and an intelligent attitude by both the patient and his family is emphasized.

Institutional

Research Grants and Awards

The American Speech and Hearing Foundation has announced a $500 Audiology Research Grant to James T. Graham, a doctoral candidate in audiology at Stanford University. The award was made possible by a grant to the Foundation by the Zenith Radio Corporation.

The American Speech and Hearing Foundation has also awarded a $500 scholarship to Joseph W. Howard, a Stanford University graduate student. This scholarship was made possible by a grant from United Cerebral Palsy Research and Educational Foundation to the American Speech and Hearing Foundation.

Some of the grants in special education and rehabilitation follow:

Colorado State College, Greeley, Colorado, $4,000, Educational Workshop, "Education of Children with Multiple Handicaps with Emphasis on Cerebral Palsy," Tony D. Vaughan, Ph.D.

Georgia State Department of Education, Atlanta, Georgia, $1,257, Educational Workshop, "Newer Concepts of Teaching and Working with the Hospitalized, Homebound and Crippled Child in the Classroom," Mamie J. Jones, Ph.D.

Northwestern University, Evanston, Illinois, $2,500, Educational Workshop, "A Program for Training Speech and Language Therapists for Persons Having Damage to the Central Nervous System," Harold Westlake, Ph.D.

San Francisco State College, San Francisco, California, $3,000, Vocational Workshop, "Education and Care of Children with Cerebral Palsy with Special Emphasis on Aphasia," Leo F. Cain, Ph.D.

University of Georgia College for Education, Athens, Georgia, $2,494, "Institute on Problems of Supervision of Special Education Programs," Stanley Ainsworth, Ph.D.

Institute for the Crippled and Disabled, New York City, $60,000 (three-year grant), "Development of Work Classification System for the Cerebral Palsied, based on Unified Medical, Physical and Emotional Data," Martin G. Moed

Programs

The University of Southern California announces a restricted graduate program for speech pathologists who wish to develop psychotherapeutic skills. The program may lead to a M.A. or Ph.D., or may be nondegree, but a minimum of two years study is required. The first year of graduate study includes courses in theories and techniques of psychotherapy, observations, and participation in group therapy so that the student may experience the psychotherapeutic process firsthand. At the end of the first year, the psychotherapeutic training faculty evaluates all candidates based on personal observations, and Rorschach and T. A. T. findings. During the second year practicum period students receive closely supervised experience in techniques of play therapy, and individual and group psychotherapy with adolescents and adults with speech difficulties. One year of practicum is the minimal requirement, but students are encouraged to extend this supervised training as far as possible.

The Rackham School of Special Education, Eastern Michigan University, Ypsilante, Michigan, has inaugurated a parent counselling program to demonstrate and to teach parents how to manage and begin training of the deaf child under school age. The clinic attempts to contact parents as soon as a diagnosis of deafness has been made. The youngest child seen to date was 11 months of age. Children and parents admitted to the program will be seen weekly until the child reaches an age to be admitted to the preschool program at the Rackham School or other placement is arranged.

Seventy-five representatives from more than 50 national health agencies and professional societies attended the Second Conference on Recruitment, sponsored by the Commission on Health Careers, National Health Council, in New York City, October 1-2, 1959. Dr. John D. Porterfield, Deputy Surgeon

General, United States Public Health Service, urged the tapping of the large reservoir of talent and brains among the nation's youth to meet the health manpower shortage. He pointed out that only 35% of the college-qualified youth ever complete college. He blamed this in rural areas, on a nonintellectual tradition and the psychic isolation which excludes potential groups from professional education. Dr. Porterfield also noted the prejudice against female intellectualism. Women, who comprise only one-third of the students in colleges and universities, have been neglected in career case-finding programs. Dr. Alvin C. Eurich, Chairman of the Commission on Health Careers, emphasized the importance of developing wider use of lesser trained, but dedicated workers, to conserve the time and energy of professional workers.

A Governor's Council on Rehabilitation has been appointed in New York to advise Governor Rockefeller and the State's Interdepartmental Health Resources Board. Leonard W. Mayo, Executive Director of the Association for the Aid of Crippled Children of New York, has been named chairman of the council. Another part of the rehabilitation program would increase the number of employed rehabilitated disabled persons through the vocational rehabilitation program of the State Education Department. During the past fiscal year 5,504 disabled persons, an increase of 1,890 over 1958, have been rehabilitated. Under this program a person is not considered rehabilitated until he has been successfully employed for one month.

William M. Brown, Chairman, Public Information Committee, the Hearing Aid Industry Conference, has written to local hearing aid dealers urging them to explore ways of strengthening relationships with the medical man, public health officer, and clinical audiologist. Suggested activities included annual conferences without publicity to encourage off-the-record freer participation of the others.

On Other Fronts

According to the *Journal of the Acoustical Society of America*, a new publication entitled, *Noise Abatement Digest*, is to be inaugurated by the National Noise Abatement Council, Inc. The bi-monthly issues will present in digest form nontechnical facts on noise reduction. For further information: Mr. L. J. Buttolph, Executive Secretary of the National Noise Abatement Council, 51 East 42nd Street, New York 17, New York.

Personals

Calvin W. Pettit, Ph.D., has been appointed Assistant Dean, Columbian College, George Washington University, Washington, D.C. Professor Pettit will continue to serve as Director of the Speech Clinic at the University, a position he has held since 1946.

James H. Platt, Ph.D., has been appointed Director of Special Education at Eastern Montana College of Education, Billings, Montana. In this position, Dr. Platt is also in charge of the Speech Correction and Audiology Curriculum.

Miss Carol M. Crotty has been appointed Supervisor of Speech Correction for the Chicago Public Schools. Miss Crotty has had experience in both public school speech correction and classroom teaching. Mrs. Edith W. Munson has been appointed Supervisor of the Education of the Deaf and Hard of Hearing for the Chicago Public Schools. Both elementary and secondary school classes for the deaf and hard of hearing will be under Mrs. Munson's supervision.

Necrology

Senator William Langer died of a heart attack in Washingington, D. C., on November 8, 1959. Senator Langer, who was born September 30, 1886 in Casselton, North Dakota, was graduated from the law division of the University of North Dakota in 1906 and from Columbia University, New York City, in 1910. His wife, Lydia Cady, had died in August. They were the parents of four daughters.

Senator Langer held public office for 43 years including two terms as Governor of North Dakota. He had served as a United States Senator for North Dakota since 1940. Among his senate committee appointments were: Foreign Relations Committee; Judiciary Committee, Chairman, 1953-54; and Post Office and Civil Service Committee, Chairman, 1947-48.

Senator Langer was well-known in the senate for his colorful and independent behavior. He was the avowed champion of the "underdog" and was considered very "liberal" in his support of domestic issues.

His interest in and support of legislation concerned with education, the handicapped, and welfare services, brought him the respect and support of many. Contributions in his honor have been made to the American Speech and Hearing Foundation.

ASHA-PURDUE — OFFICE OF EDUCATION STUDY

Nine working groups of ASHA members, 115 individuals actively participating at the time of the new year, are now engaged in the collection of data for the National Study on Public School Speech and Hearing Services, according to Dr. M. D. Steer, director of the study. Moreover, each day's mail brings in a new offer of assistance from someone in the field, report members of the resident research staff at Purdue University. Despite this gratifying response to the call for volunteers, many more can be utilized in various aspects of the investigation. Members should communicate their interest to Dr. Steer.

The primary task currently occupying area work groups is preparation of questionnaire items designed to yield information about case loads, salary scales, scheduling and many other aspects of public school speech correction. Eventually these questionnaires will be submitted to a broad sample of the membership and analyzed for national, regional and local trends. The effort will be to learn the present status of this large segment of the profession, and to discover where areas of doubt, uncertainty, and even disagreement with current practices lie. Frank Garfunkel, project research associate, will prepare the final questionnaire forms, direct their distribution and submit responses to statistical analysis.

In addition to the general task of project coordination, the resident staff at Purdue University is engaged in assembling official information, laws, regulations, etc., from the state departments of public instruction and divisions of special education. Many states have not responded to requests for such information, and individual members are requested to forward to Dr. Betty Ann Wilson, Purdue Speech and Hearing Clinic, any such official information they may possess. Also, the resident staff urges that officers of state associations forward directories and any other relevant information to Dr. Wilson.

NEW

Maico Group Hearing Aid

to teach Hard of Hearing Classes

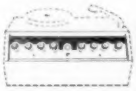
Maico MT-1
GROUP HEARING AID
for classroom instruction

An ideal unit for teaching a group of students with severe hearing losses. Its simplicity of master controls makes it possible for the teacher to devote complete attention to students and yet each student has individual controls to adjust to his hearing handicap.

EXCLUSIVE Maico FEATURES

HEADSETS—Allows up to 20 students selective levels of amplification in either ear. Individual controls are provided for each student in a classroom.

MICROPHONE; TURN-TABLE — Three separate microphone input channels are provided, each regulated by separate dial on master panel. Has 3 speed phonograph and inputs for radio, television and movies.



CONTROL PANEL — All controls, operated by the teacher, conveniently located on one panel. Students have individual controls.

"HUSH" CIRCUIT CONTROL—Exclusive circuit prevents the unit from amplifying any background sounds except those spoken directly into the microphone. An ideal feature for obtaining normal classroom procedure.

NEW MAICO *PORTABLE DESK TYPE HEARING AID*

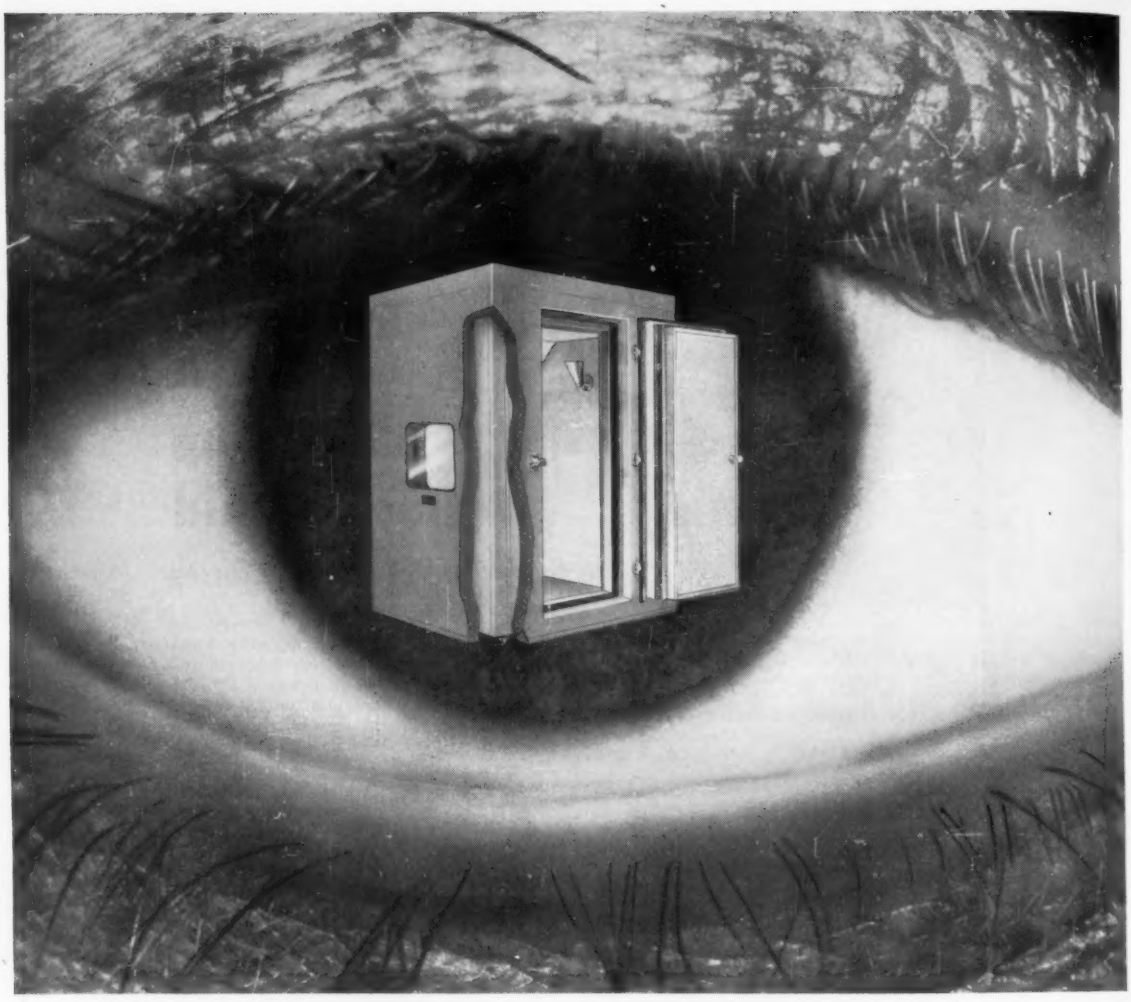
Ideal for home or classroom use

Maico's new battery-operated desk type hearing aid has been designed specially for auditory training at home and in the school. Weighs only 4 pounds complete with batteries. No electricity used.

Write for further details and specifications

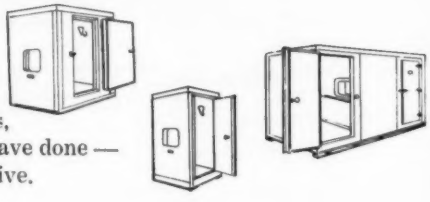
MAICO

Room 129
21 North Third Street
Minneapolis, Minnesota



More than meets the eye...

Only x-ray vision can see the thousands of research and development hours which have given IAC Audiometric Examination Rooms engineered construction and guaranteed performance.



Do as hundreds of hospitals, speech and hearing clinics, medical research laboratories and industrial clinics have done — before buying or building, consult an IAC Representative. You will save both time and money.

Professional literature furnished on request.

Medical Department AS-1A

Industrial Acoustics Company, Inc.

341 Jackson Avenue, New York 54, N.Y.

Calendar of Professional Events

NATIONAL

March 27—April 2	Golden Anniversary, White House Conference on Children and Youth, Washington, D.C.
April 19-23	Annual Conv., Council for Exceptional Children, Biltmore, Hotel, Los Angeles, Calif.
April 24-28	American Association of Orthodontists, Washington, D.C.
May 2-11	35th Anniversary, Congress Pan American Medical Association, Mexico City, Mexico.
May 5-6	Annual Meeting President's Committee on Employment of the Physically Handicapped, Washington, D.C.
May 12-14	American Association of Cleft Palate Rehabilitation, Denver, Colorado.
June 27-July 1	Alexander Graham Bell Association for the Deaf, Rochester, New York.

STATE

February 11-12	2nd Alabama Conference on Handicapped Children: Speech & Hearing Problems, University of Alabama, Tuscaloosa, Alabama.
April 28-30	Ohio Speech and Hearing Association, Van Cleeve Hotel, Dayton, Ohio.
May 13-14	Indiana Speech and Hearing Association, Purdue University, Lafayette, Indiana.

He breaks the sound barrier . . .

WITH AUDIVOX HEARING AIDS

There are almost more miles than people in Grant Born's territory. But Dr. Born doesn't miss a single hearing problem.

How does he keep up with them? Grant Born makes it easy — *he flies his own plane.*

As head of the Petoskey Hearing Aid Center in Petoskey, Michigan, Dr. Born has two other distributors helping him to take care of his widely scattered franchise, and this year he expects to add two more. And every year — every month — more and more hearing loss sufferers thank Dr. Born for removing their "sound barrier" by fitting them with Audivox hearing aids.

But aviation alone could not carry Dr. Born through his vast territory. There are other ingredients . . . enormous enthusiasm, a scrupulous attention to the details of each individual's hearing aid needs, a genuine feeling of responsibility towards the people who bring him their hearing problems.

Dr. Born himself names *Audivox* as one of the biggest reasons for the steady growth of the Petoskey Hearing Aid Center. To put it simply, Grant Born believes in Audivox products and in the integrity of the company that makes them. Most important, he knows that Audivox works with him to bring better hearing to the people of his area.

Dr. Born's story exemplifies the dedication and industry of the Audivox family of distributors. Today, throughout the United States, these men are bringing the miracle of hearing to more people than ever before.

audivox HEARING AIDS

Successor to the *Western Electric* Hearing Aid Division

Audivox Hearing Aids are licensed under patents of the American Telephone and Telegraph Company, and Bell Telephone Laboratories, Incorporated.

Home offices and Main Plant 123 Worcester Street, Boston 18. KEnmore 6-6207.

Forum

CONVENTION COMMENTS

Each ASHA Convention outdoes the previous ones. Between the professional meetings and parties everyone there should have been satisfied. Congratulations to the committee.

If suggestions are in order for future consideration, here are a few. Although the outstanding contributors deserve honor and recognition, much of what they will say is already well known. This is especially true of stuttering where some treatment is needed to break up patterns of sterile stereotopy. One gets a feeling that the mysticism of the high priests precludes challenge to a committed dogma. Let a group of speech therapists (or whatever!) tell what they really feel about the limited concepts and therapies.

We are trying to grow professionally; let us constructively criticize our own house. Discuss the personality of the speech therapist versus his techniques in getting results. Why use voluntary repetitions or prolongations or pull-outs when these could reinforce the mechanical aspects of stuttering? Investigate the operational definition of aphasia. How can you know about aphasia if it isn't expressive? Let's use more individual cases as well as mean trends who works with a mean in human form? Why think of only the theoretical?

It is gratifying that after my suggestion of six years ago, there is an attempt to integrate research for practical purposes. We know our needs and have faith in their fulfillment.

Elliott J. Schaffer
Iowa State Teachers College

I have been prompted to say a few words about the 1959 ASHA Convention, and to make a few suggestions for future Conventions. No, I am not annoyed with inconveniences! I was very pleased with the Convention. I want to congratulate Dr. Miriam Pauls and the Program Committee for a splendid Convention program.

The program was well-planned. The variety of offerings should have met the interests, needs, and levels of sophistication of any and every member in attendance.

Accommodations could have been better so far as hotel arrangements were concerned. The weatherman did not cooperate in the necessary movements from one hotel to another.

The good points of programing, timing, and variety of offerings more than compensated for the small inconveniences.

The pattern followed in the two sections: (1) Research on Auditory Stimulation and Discrimination and (2) Implication for therapy, should be used more generally in programs in the future. Many times the implications are not evident to young speech correctionists.

The first general meeting was both interesting and enlightening. It would seem that the presentation of initial and important issues should be included in each Convention program.

The selection of individuals from all parts of the country for the program certainly gives us a bird's-eye view of the policies and practices prevalent on a nationwide level. This should certainly be continued.

The programs presented at this Convention seemed to have greater "holding power." The people in the audiences seemed to stay until the end of the program and there was not so much moving in and out of section meetings.

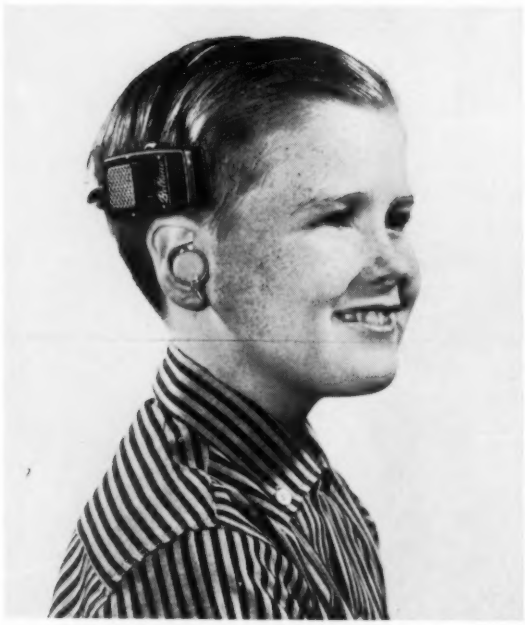
I believe this was an outstanding program and I wish to congratulate the planning committee before we get so involved in our every day affairs that we forget about the work of this group that planned the wonderful Convention in 1959.

Elsie M. Edwards
Michigan State University

ANNOUNCING THE *Beltone*

TRUE BINAURAL TRAINING AID

for use in schools for the deaf, clinics, etc.



Developed solely by the laboratories that pioneered binaural hearing among the hard of hearing, this new instrument is different from any other training aid because it provides:

1. TRUE BINAURAL—Experts have long recognized a need for a binaural training aid providing hearing in both ears at natural ear level. Scientific tests prove that this is the easiest way to train the deaf to hear accurately and to speak more naturally. The Beltone binaural training aid is equipped with separate microphone, amplifier and receiver for each ear. Each microphone is placed very close to the ear for which it is intended.

2. MOBILITY—Unlike previous training aids, this new Beltone unit is NOT connected to anything. There is nothing to plug in and unplug. The pupil wears the entire hearing instrument on his head, so that when he goes to the blackboard or to another room he hears just as well as when seated at a desk.

Further, this new Beltone instrument does *not* require that the teacher speak into a microphone mounted on a desk. Instead, the teacher can move about at will and the receivers on the pupils' hearing aids will pick up the voice.

The price of Beltone's binaural training aid is $249.50, which includes 2 training aids with adjustable headbands, 2 cords, 2 receivers, and 2 batteries. For complete factual information, simply mail us the coupon for a free, fully illustrated brochure. No obligation.

send today for your free brochure

Beltone

HEARING AID COMPANY

2900 West 36th Street, Chicago 32, Illinois

Beltone Hearing Aid Company, Dept. 9-235
2900 W. 36th St.,
Chicago 32, Illinois

Please send me your free brochure DM-182 describing the Beltone Binaural Training Aid.

Name_____

Address_____

City_____ Zone____ State_____